Summary Plan Description
United HealthCare Choice Plan
for
the State Health Benefit Plan

Group Number: 702030
Effective Date: January 1, 2006

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Introduction

We are pleased to provide you with this Summary Plan Description (SPD). This SPD describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this SPD by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 9: General Legal Provisions) to better understand how this SPD and your Benefits work. You should call United HealthCare if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your SPD and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

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Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms). You can refer to Section 10 as you read this document to have a clearer understanding of your SPD.

When we use the words "we", "us", and "our" in this document, we are referring to SHBP. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

Customer Service and Claims Submittal

Please make note of the following information that contains United Healthcare department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures): As shown on your ID card, 1-866-527-9599

Prior Notification: As shown on your ID card, 1-866-527-9599
For detailed explanation see page 6.

Mental Health/Substance Abuse Services: 1-866-527-9599

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Claims Submittal Address:

United HealthCare Insurance Company

Attn: Claims

PO Box 740806

Atlanta, Georgia 30374-0800

Requests for Review of Denied Claims/Appeals and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

PO Box 30994

Salt Lake City, Utah 84130-0432

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you or your provider to notify United HealthCare before you receive them. In general, Network providers are responsible for notifying United HealthCare before they provide certain health services to you.

Accessing Benefits

You must see a Network Physician to obtain Benefits. For details, see (Section 3: Obtaining Benefits).

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

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Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 10: Glossary of Defined Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee. In almost all cases our designee is United HealthCare. For a complete definition of Eligible Expenses that describes how payment is determined, see (Section 10: Glossary of Defined Terms).

We have delegated to United HealthCare the discretion and authority to determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

To continue reading, go to left column on next page.

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills.

Notification Requirements

In general, Network providers are responsible for notifying United HealthCare before they provide these services to you. There are some Benefits, however, for which you are responsible for notifying United HealthCare.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. We will pay for covered Health Services as secondary payer as described in (Section 7: Coordination of Benefits). You are not required to notify United HealthCare before receiving Covered Health Services.

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms). The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. For a complete definition of Eligible Expenses, see (Section 10: Glossary of Defined Terms).	$200 per Covered Person per calendar year, not to exceed $400 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay for Covered Health Services in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	$1,000 per Covered Person per calendar year, not to exceed $2,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.

Payment Term	Description	Amounts
Maximum Plan Benefit	The maximum amount we will pay for Covered Health Services during the entire period of time you are enrolled under The State Health Benefit Plan (SHBP). For a complete definition of Maximum Plan Benefit, see (Section 10: Glossary of Defined Terms).	$2,000,000 per Covered Person (combined for all SHBP options)

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	*Ground Transportation:* 0% *Air Transportation:* 0% Non-emergency when part of a monitored, authorized care plan.	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
2. Dental Services:			
A. Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. (Benefit information continued on next page)	Inpatient and Outpatient facility charges 0% Office Visit copayment $25	No No	Yes No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. **Notify United Healthcare** Please notify United Healthcare at the telephone number on your ID card as soon as possible, but at least five business days before follow-up (post Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment).			
B. Oral Care The Plan has limited dental and oral care benefits. Prior Approval may be required - contact Care Coordination. The Plan will consider coverage only for: • Prompt Repair of natural teeth or tissue in connection with reconstructive surgical procedures following treatment of oral cancer, • Surgery to treat lesions of the mouth, lip or tongue, if the lesion requires a pathological examination, • Surgery (frenulectomy) for treatment of a child's speech impairment, when medically indicated	Inpatient and Outpatient facility charges 0%	No	Yes
	Oral surgery in an office $25	No	No

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Surgery of accessory sinuese, salivary glands or ducts, - surgery to repair cleft palates, • Orthognathic surgery to correct obstructive sleep apnea and for dependents age 19 and under born with specific craniofacial syndromes, and • Institutional and anesthesia charges associated with a non-covered dental care normally performed in a dental office, but due to the patient's medical condition, care in a Hospital setting is warranted, as required under State Law. Repairs that are not performed promptly (as defined) will be denied unless a compelling medical reason exists. X-Rays and other documentation may be required to determine benefit coverage.			
C. Temporomandibular Joint Dysfunction (TMJ) Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Benefits include necessary diagnostic or surgical treatment required as a result of accident, trauma, congenial defect, developmental defect, or pathology. Benefits are not available for charges or services that are dental in nature, including appliances and orthodontic care.	Inpatient and Outpatient facility charges 10% Office visit copayment $25	Yes No	Yes No

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
D) Wisdom Teeth (Impacted Only) Impacted wisdom teeth are covered under the medical plan. If wisdom teeth are not impacted this will be covered under the dental plan.	$25 per visit	No	No
3. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.	0%	No	No

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service.
- Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditions, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every calendar year.

United HealthCare will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor United HealthCare identifies.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
4. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).	$100 per visit	No	No
5. Eye Examinations Eye examinations received from an In-Network health care provider in the provider's office. Benefits include one routine visit every 24 months. Non-Routine eye exams are covered the same as any other specialist medical visit and there is no limitation on the number of visits. If hardware is purchased from a par provider the member does not need to pay in full and submit a claim form. **The par provider will submit the claim form and be reimbursed the negotiated rate up to $200.** If a non par provider is used the member must pay the expenses and file the claim form for reimbursement. The vision claim form must be filled out by the provider of service. Print the vision claim form prior to your visit. The form can be found on www.myuhc.com. If you do have access to the Internet you may contact Customer Service to have one faxed or mailed to you. (Benefit information continued on the next page)	$25 per visit **A $200 benefit per calendar year for combination of glasses and/or contacts.**	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Eye examinations received from a health care provider, for diagnosis and treatment of eye condition. NOTE: We will cover eyeglasses (first pair only) after cataract surgery.			
6. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Up to four hours of skilled care services. Benefit limit to 120 visits per calendar year. Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician.	0%	No	No

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care. United HealthCare will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.			
7. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.	0%	No	No

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Please contact United HealthCare for more information regarding guidelines for hospice care. You can contact United HealthCare at the telephone number on your ID card. Benefits are limited to 360 days during the entire period of time you are covered under the Plan. Benefits for bereavement are limited to 8 visits per calendar year.			
8. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Benefits for Physician services are described under *Professional Fees for Surgical and Medical Services.*	10%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
9. Infertility Services Services for the treatment of infertility (for underlying medical condition only) when provided by or under the direction of a Network Physician. We will cover diagnostic testing to rule out a diagnosis, but once diagnosed it is not covered. Please also refer to Section 2: What's Not Covered—Exclusions under item L. Reproduction.	10%	Yes	Yes
10. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	0% per injection	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
11. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify United HealthCare during the first trimester, but no later than one month prior to the anticipated delivery date. We will pay for an Inpatient Stay of at least: • ***According to Federally Mandated Guidelines we will pay** 48 hours for the mother and newborn child following a normal vaginal delivery. • **According to Federally Mandated Guidelines we will pay** 96 hours for the mother and newborn child following a cesarean delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.	0% for Physician inpatient charges No Copayment applies to Physician office visit for prenatal care after the first $25 visit	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
12. Mental Health and Substance Abuse Services - Outpatient Please remember that you must call United Behavioral Health and get authorization to receive these Benefits in advance of any treatment United Behavioral Health (UBH). The UBH phone number that appears on your ID card is 1-866-527-9599. Benefits for Mental Health Services and/or Substance Abuse Services are limited to 25 visits per calendar year. Please contact UBH prior to receiving services to verify you are using a UBH provider – no benefits will be paid if a UBH provider is not used. Without authorization, you will be responsible for paying all charges and no Benefits will be paid. Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy).	$25 per individual visit; $10 per group visit.	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
13. Mental Health and Substance Abuse Services - Inpatient and Intermediate **Authorization Required** Please remember that you must call and get authorization to receive these Benefits in advance of any treatment UBH. The UBH phone number that appears on your ID card is 1-866-527-9599. Benefits for Mental Health Services and/or Substance Abuse Services are limited to 30 days per calendar year. Without authorization, you will be responsible for paying all charges and no Benefits will be paid. Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being.	10%	Yes	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
14. Ostomy Supplies Benefits for ostomy supplies include only the following: • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. • Urinary Catheters. Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	0%	No	No
15. Outpatient Surgery, Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Surgery and related services. • Lab and radiology/X-ray. • Mammography testing. (Benefit information continued on next page)	10% ***For mammography testing:*** Routine: 0% Non-routine: 10%	Yes No Yes	Yes No Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). Benefits under this section include only the facility charge, the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under Professional Fees for Surgical and Medical Services.	**0% for all preventative lab, X-ray and Diagnostic services regardless of place of service**		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Physician's Office Services **Covered Health Services for preventive medical care.** **Preventive medical care includes:** • Preventive medical care. • Well-baby and well-child care. • Routine physical examinations. • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examinations* earlier in this section.) • Immunizations. • Mammograms	$20 per PCP visit $25 per Specialist visit No Copayment applies when no Physician charge is assessed. Expenses for routine mammograms 0%, regardless of place of service 0% for preventive medical services and all related services, except for the office visit charge which is subject to the office visit copayment.	No	No

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	$20 per PCP visit $25 per Specialist visit No Copayment applies when no Physician charge is assessed.	No	No
17. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	10%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Prosthetic Devices External prosthetic devices that replace a limb or an external body part, limited to: • Artificial arms, legs, feet and hands. • Artificial eyes, ears and noses. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every calendar year.	0%	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
19. Reconstructive Procedures Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Covered Health Service. You can contact United HealthCare at the telephone number on your ID card for more information about Benefits for mastectomy related services.			
20. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. (40 visits) • Occupational therapy. (40 visits) • Speech therapy. (40 visits) • Pulmonary rehabilitation therapy. (40 visits) • Cardiac rehabilitation therapy. (40 visits) Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.	$25 per visit	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Benefits are limited to 120 days per calendar year. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.	10%	Yes	Yes
22. Spinal Treatment, Chiropractic & Osteopathic Manipulative Therapy Benefits for Spinal Treatment when provided by a Network Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Benefits for Spinal Treatment are limited to 20 visits per calendar year.	$25 per visit	No	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
23. Transplantation Services Under the Plan there are specific guidelines regarding Benefits for transplant services. **Contact United HealthCare at the telephone number on your ID card for notification and information about these guidelines**. Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service: • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants.	10%	Yes	Yes

(Benefit information continued on next page)

- Liver transplants.
- Liver/small bowel transplants.
- Pancreas transplants.
- Small bowel transplants.

Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.

Transportation and Lodging

United HealthCare will assist the patient and family with travel and lodging arrangements when services are received from a Designated Facility. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people. • Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility. • If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate. There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.			
24. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	$25 per visit	No	No

Section 2: What's Not Covered--Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions regardless of medical necessity. This section lists some (but not all) of the things the plan does not cover at all, under any circumstances.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

To continue reading, go to right column on this page.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 1: What's Covered--Benefits) or through a Rider to the SPD.

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Environmental Medicine services or homeopathic/holistic/alternative medicine services, including visits, diagnostic testing, labs, medication, or procedures from Provider of these practices.

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B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - — Air conditioners.
   - — Air purifiers and filters.
   - — Batteries and battery chargers.
   - — Dehumidifiers.
   - — Humidifiers.
6. Devices and computers to assist in communication.
7. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
8. Air cleaners and dust collection device.
9. Vacuum erection devices (VED, erec aid) to stimulate the penis.
10. Duplication, upgrade or replacement of currently function equipment.

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C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   - — Extraction, restoration and replacement of teeth, including impacted wisdom teeth.
   - — Medical or surgical treatments of dental conditions.
   - — Services to improve dental clinical outcomes.
3. Dental implants or associated services such as bone grafts for the placement of dental implants.
4. Dental braces and Orthodontics.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   - — Transplant preparation.
   - — Initiation of immunosuppressives.
   - — The direct treatment of acute traumatic Injury, cancer or cleft palate.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.
7. Alveoplasty; vestibuloplasty, apicoectomy; excision of manibular tori or exostosid; occlusal devices or their adjustment; splints for bruxism (clenching or grinding of teeth).

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8. Surgery, appliances or prostheses such as crown, bridges or dentures; fillings; endodontic care; treatment of dental caries; excision of radicular cysts or granuloma; treatment of periodontal disease; except as noted; and associated charges with any non-covered or oral service or supply.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments.

Refer to the outpatient Prescription Drug Rider for benefits.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

To continue reading, go to right column on this page.

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses).
2 Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include the following:

   — Cleaning and soaking the feet.

   — Applying skin creams in order to maintain skin tone.

   — Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoe and foot orthotics.
1. Foot care devices such as arch supports, orthotics and routine foot care, for example treatment of fallen arches, flat feet and chronic foot strain.
2. Footwear of any kind, including diabetic shoes, unless permanently attached to a covered brace.

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G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - — Ace bandages.
   - — Gauze and dressings.
   - — Syringes.
   - — Diabetic test strips. ****Please refer to Pharmacy Benefits Handbook.**
3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered--Benefits).
5. Hot and cold packs.
6. Breast pumps.
7. Blood pressure cuffs (unless related to dialysis).
8. Lift for scooters and wheelchairs, stair glides and elevators, and any other home modifications.
9. Devices and computers to assist in communication.
10. Vacuum erection devices (VED, erec aid) to stimulate the penis.
11. Duplication, upgrade or replacement of currently functioning equipment.

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

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2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention and stabilization.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Residential treatment services and transitional living.
8. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   - — Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - — Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.

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— Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.

— Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups.
3. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms). Examples include:

   — Pharmacological regimens, nutritional procedures or treatments.

   — Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).

   — Skin abrasion procedures performed as a treatment for acne.

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2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss except for wigs required as a result of cancer.
6. Hair removal, including electrolysis.

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   — Has not been actively involved in your medical care prior to ordering the service, or

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— Is not actively involved in your medical care after the service is received.

L. Reproduction

1. In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures and any other reproductive technology.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Infertility monitoring, correction or treatment.
5. Storage of egg, sperm or blood product for future use.
6. Infertility drugs and reproductive medicines.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

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N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services and expenses for transplants involving artifical, mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.
5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits).
7. Lodging related to, except as defined in (Section 1: What's Covered –Benefits *Transplantation Services*) the donation or transplantation of an organ.
8. Transplant therapy used as a palliative procedure. Transplant therapy considered experimental.

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

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P. Vision and Hearing

1. Purchase cost of hearing aids.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy and/or orthoptic training.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery, including LASIK.
5. Diagnosis, treatment or surgical and non-surgical correction of far-sightedness, near-sightedness or astigmatism. Any vision care, including low-vision and other vision aids.
6. Tinnitis therapy, including sound generators

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - — Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - — Related to judicial or administrative proceedings or orders.
   - — Conducted for purposes of medical research.
   - — Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

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4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature.
8. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
9. Non-surgical treatment of obesity, for example Optifast, including morbid obesity.
10. Surgical treatment of obesity including severe morbid obesity, gastric restrictive procedures, abdominoplasty, repair of diastasis recti, tummy tuck, excision of excessive skin and/or subcutaneous tissue, and liposuction.
11. Growth hormone therapy, with the exception of diagnostic testing to rule out a diagnosis. Once diagnosed growth-hormone therapy is not covered.
12. Sex transformation operations.
13. Custodial Care and Day programs.
14. Domiciliary care.
15. Private duty nursing.
16. Respite care.
17. Rest cures.
18. Psychosurgery.

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19. Treatment of benign gynecomastia (abnormal breast enlargement in males).
20. Medical and surgical treatment of excessive sweating (hyperhidrosis).
21. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
22. Oral appliances for snoring.
23. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
24. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
25. Any charge for services, supplies or equipment advertised by the provider as free.
26. Any charges prohibited by federal anti-kickback or self-referral statutes.

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Section 3: Obtaining Benefits

This section includes information about:
- Obtaining Benefits.
- Emergency Health Services.

Benefits

Benefits are payable for Covered Health Services which are any of the following:

- Provided by or under the direction of a Network Physician or other Network provider in the Physician's office or at a Network facility.
- Emergency Health Services.
- Urgent Care Center services received outside the service area.

Benefits are not payable for Covered Health Services that are provided by non-Network providers.

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Abuse*.

Provider Network

United HealthCare arranges for health care providers to participate in a Network. Network providers are independent practitioners.

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They are not our employees or employees of United HealthCare. It is your responsibility to select your provider.

The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

You will be given a directory of Network providers. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling United HealthCare.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some products. Refer to your provider directory or contact United HealthCare for assistance.

Care Coordination[SM]

Your Network Physician is required to notify United HealthCare regarding certain proposed or scheduled health services. When your Network Physician notifies United HealthCare, they will work together to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

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If you receive certain Covered Health Services from a Network provider, you must notify United HealthCare. The Covered Health Services for which notification is required is shown in (Section 1: What's Covered--Benefits). When you notify United HealthCare, you will be provided with the Care Coordination services described above.

Designated Facilities and Other Providers

If you have a medical condition that United HealthCare believes needs special services, they may direct you to a Designated Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, United HealthCare may direct you to a non-Network facility or provider.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility or other provider chosen by United HealthCare.

You or your Network Physician must notify United HealthCare of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. If you do not notify United HealthCare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Benefits for Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify United HealthCare, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, we will pay Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Limitations on Selection of Providers

If United HealthCare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, United HealthCare will select a single Network Physician for you. If you fail to use the selected Network Physician, Benefits for Covered Health Services will not be paid.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician. Non- Emergency use of the Emergency Room is not covered.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, United HealthCare must be notified within one business day or on the same day of admission if reasonably possible. United HealthCare may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If

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you choose to stay in the non-Network Hospital after the date United HealthCare decides a transfer is medically appropriate, Benefits will not be available.

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

Note: If any conflict exists between this summary plan description and the laws of the State of Georgia or with the polices of the State Health Benefit Plan (SHBP), the laws of the State of Georgia or the polices of SHBP will govern at all times.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. SHBP or its designee will give the necessary forms to you, along with instructions about submitting your enrollment form and any required contribution for coverage. We will not provide Benefits for health services that you receive before your effective date of coverage.

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If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify United HealthCare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Benefits are available only if you receive Covered Health Services from Contracted Providers.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	You are eligible to enroll yourself and your eligible dependents for coverage if you are: • A Full-time employee of the State of Georgia, the General Assembly, or an agency, board, commission, department, county administration, or contracted employer that participates in SHBP, as long as: — You work at least 30 hours a week consistently, and — Your employment is expected to last at least nine months. Not Eligible: Student employees or seasonal, part-time, or short-term employees. • A certified public school teacher or library employee who works half-time or more, but not less than 18 hours a week. Not Eligible: Temporary or emergency employees. • A non-certified service employee of a local school system who is eligible to participate in the Teachers Retirement System or its local equivalent. You must also work at least 60% of a standard schedule for your position, but not less than 20 hours a week. • An employee who is eligible to participate in the Public School Employees' Retirement System as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated. You must also work at least 60% of a standard schedule for your position, but not less than 15 hours a week.	SHBP determines who is eligible to enroll.

Who	Description	Who Determines Eligibility
	• A retired employee of one of these listed groups who was enrolled in the Plan at retirement and is eligible to receive an annuity benefit from a state-sponsored or state-related retirement system. See Provisions for Eligible Retirees for details of retiree medical coverage. • An employee in other groups as defined by law.	
Dependent	Eligible dependents are: • Your legally married spouse • Your never-married dependent children who are: • (1) Natural or legally adopted children under age 19, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody. • (2) Stepchildren under age 19 who live with you at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents. • (3) Other children under 19 if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction. • Your natural children, legally adopted children or stepchildren 19 or older from categories 1 and 2 above who are physically or mentally disabled prior to reaching age 19 and who depend on you for primary support may continue their existing Plan coverage past age 19.	SHBP determines who is eligible to enroll.

- Your natural children, legally adopted children, stepchildren or other children age 19 to 26 from categories 1, 2 and 3 above who are registered Full-time Students at fully accredited schools, colleges, universities, or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for Full-time Student status is defined by the school in which the child is enrolled.

When requested by the Plan, you will be required to provide documents such as a marriage license, birth certificate, adoption contract or judge-signed court order to verify your dependent relationship. The Plan has the right to determine whether or not the documentation satisfies Plan requirements. If verification cannot be made, the dependent's coverage will be terminated retroactively to his or her coverage effective date. The Plan will make every effort allowable under the law to recover from the Participant any and all payments made by the Plan on behalf of an ineligible dependent.

Documentation Required For Eligible Covered Dependents Age 19 or Older

Coverage does not continue automatically at age 19. This chart describes what you must do to request continued coverage as your child nears age 19.

For a Covered Dependent age 19 & older…

- … and a Full-time Student under the age 26

You must:

- update SHBP annually on student status by requesting a *certification letter* from the school's registrar and sending it with a *Dependent Student Status Information Form* to SHBP
- the certification letter must include:
  - — enrollment date(s) for both current and previous quarters or semesters
  - — number of credit-hours taken each quarter or semester
  - — enrollment status (full- or part-time) for each quarter of semester

For a Covered Dependent age 19 & older…

- … and disabled as a covered SHBP Member before age 19

You must:

- file a written request for continuation of coverage prior to the 19th birthday or within 90 days after the 19th birthday and provide satisfactory documentation of disability

If you have a disabled child who is already age 19 when you enroll, the child is not eligible for coverage. However, if your disabled child loses coverage under another plan, you may apply for SHBP coverage on the child if the child *were eligible for SHBP coverage on your child's 19th birthday*.

To apply, send the Plan a written request and documentation on your child's disability and loss of other coverage within 90 days of the dependent's loss of coverage. You must be a Member when application is made.

A general note regarding documentation sent to the Plan: While the Plan requires that coverage requests are made within a specific time period, the documentation required *to support your request* may be filed later, if necessary within the 60 days following the deadline to file the coverage requested.

Qualified Medical Child Support Order (QMCSO)

SHBP will honor a QMCSO for eligible dependents. A QMCSO creates, recognizes, or assigns the right for a dependent to receive benefits under a health plan. See *Glossary of Key Terms* and *Coverage Changes At Qualifying Events* for more information.

Who's Not Eligible For Dependent Coverage

The most common examples of persons not eligible for SHBP dependent coverage include:

- Your former spouse
- Your fiancé
- Your parents
- Married or formerly married children
- Children age 19 or older who do not qualify as Full-time Students or disabled dependents
- Children 26 or older who are not already covered as a disabled dependent

Who	Description	Who Determines Eligibility
	• Children in military service • Grandchildren who cannot be considered eligible dependents • Stepchildren who do not live in your home at least 180 days per year • Anyone living in you home that is not related by marriage or birth, unless otherwise noted	

When to Enroll and When Coverage Begins

You *must* enroll to have the SHBP coverage. To enroll, go to your personnel/payroll office for instructions. You will be asked to:

- Choose a coverage option
- Select either single coverage or family coverage
- Name the eligible dependents you want to cover

Your signature on the enrollment form authorizes periodic payroll deductions for premiums. Your employer may also ask you to complete other forms. Once you make your coverage election, changes are not allowed outside the Open Enrollment period, unless you have a qualifying event under Section 125 of the Internal Revenue Code, which restricts mid-year changes in the SHBP.

Special Note: If you terminate employment and are re-hired during the same Plan year, you must enroll in the same Plan option, provided you are eligible for that option.

Important Plan Membership Terms

The Plan uses these terms to describe Plan Membership:

- Participant – You, the contract/policy holder
- Member – You and/or your eligible dependents that you choose to enroll

Where appropriate, this SPD relies on these terms throughout the document:

- Employee, retiree or Member… to refer to Participant
- Dependent(s)… to refer to Member

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date identified by SHBP, if SHBP receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	SHBP determines the Open Enrollment Period. Coverage begins on the date identified by SHBP if SHBP receives the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible to enroll.

If you are:	You can enroll:	Your coverage takes effect:
▪ A current employee	▪ Or make coverage changes during Open Enrollment	▪ The upcoming January 1
	▪ Or make coverage changes within 31 days of a qualifying event; upon loss of all eligible dependents, within 90 days	▪ First of the month following request
▪ A newly hired employee	▪ Within 31 days of your hire date	▪ First of the month after a full calendar month of employment

If You Have Coverage through a Different Health Plan

If you elect to decline SHBP coverage, you must complete a Declination Form, available from your personnel/payroll office, and file it within 31 days of your hire date. You may not enroll until the next Open Enrollment period – unless you have a qualifying event.

Enrolling A Newly Eligible Dependent

If you have a new dependent due to marriage, birth or adoption, you may enroll your dependent if you request enrollment within 31 days of the marriage, birth or adoption.

This next chart describes what you need to do if you wish to add a newly eligible dependent.

If you have to enroll a newly eligible dependent and…		You will need to:
Newly Eligible Dependent	… you already have family coverage	File a Dependent/Miscellaneous Update Form with SHBP
	… you do *not* have family coverage	Change your coverage type to family* by filing a *Membership Form* with your personnel/payroll office
	… you have a court order requiring you to enroll dependent child(ren), such as a QMCSO.	Enroll the eligible child(ren); coverage starts on first day of month following the request. Change to family coverage if you have single coverage.

**To make coverage retroactive to the child's birth or placement, you must make family coverage premium payment(s) for coverage for the month of the birth or adoption contract and placement.*

Identification Cards

After you enroll, you will receive an identification (ID) card for yourself and eligible dependent(s), if applicable. The ID card must be presented when care is received.

If you do not receive your ID card within two weeks of enrollment, contact United HealthCare. You must contact United HealthCare Customer Service at 866-527-9599.

When Coverage Begins

For You

When your coverage starts depends on when you enroll and when you make requests that affect your coverage.

	If you enroll: During an Open Enrollment period	**Your coverage begins:** On January 1 of the new Plan Year
	As a new employee	On the first day of the month following one full calendar month of employment
	When you are reinstated or return to work from an unpaid leave of absence that occurred during the Open Enrollment period	On the first day of the month following the request or, if a judicial reinstatement, on the day specified in the settlement agreement
	When you have a qualifying event	On the first day of the month following the request

Transferring Employees

If you are transferring between participating employers:

- Contact your new employer to coordinate continuous coverage
- You must continue the same coverage, unless you had a qualifying event that made you ineligible to continue that coverage

There is no coverage lapse when your employment break is less than one calendar month and your new employer deducts the premium from your first paycheck.

For Your Dependents

When you select family coverage as a new employee, dependent coverage begins when your coverage begins.

**If necessary, you may change to family coverage before the birth to avoid retroactive premium payments.*

You must enroll for dependent coverage and submit the required form(s) within 31 days of the birth, adoption, or marriage.

If you add dependents later, coverage takes effect as described in the chart below:

	If you add this dependent…	Coverage takes effect:
When you already have family coverage	A baby Copy of certified birth certificate required upon request	On the first day of the month following the request; On the day your child was born, if the family premium is paid from the birth month.*
When you change to family coverage within 31 days of the event	An adopted child Copy of certified adoption certificate required upon request	On the date of legal placement and physical custody, if the family premium is paid from the time of placement and custody

	If you add this dependent…	Coverage takes effect:
When you already have family coverage:	A new spouse	On the day of your marriage
	Stepchild(ren) / Other child (which includes adoptions and temporary and permanent guardianship)	
	Copy of certified birth certificate showing your spouse is the natural parent; and copy of certified marriage license showing the natural parent is your spouse; and notarized statement that dependent lives in your home at least 180 days per year	
When you have single coverage		On the first day of the month following the request

Qualifying Events that Allow Coverage Changes for Active Participants

If you are an actively employed Participant and have one of the following qualifying events during the year, you may be able to make a coverage change that is consistent with the event. If you are a retiree, refer to the retiree section for permitted coverage changes. The following chart shows qualifying events and the corresponding changes that active Participants can make.

If you have one of these events:	Within 31 days of event, you may:
Marriage Certified copy of marriage certificate required	Enroll Change to family coverage Discontinue coverage; letter from other plan documenting your coverage is required
Birth, adoption or legal guardianship 1) Copy of certified birth or adoption certificate required 2) Copy of court decree showing your financial responsibility for the dependent; and copy of certified birth certificate; and notarized statement that dependent lives with you in your home on a permanent basis	Enroll Change to family coverage

	If you have one of these events:	Within 31 days of event, you may:
	You lose coverage because of divorce Copy of divorce decree and loss-of-coverage documentation required	Enroll in any available option Change your coverage type
	You or your spouse loses coverage through other employment Letter from other employer documenting loss required	Change to family coverage
	You, your spouse, or enrolled dependent loses or discontinues health benefit coverage through other employment, Medicaid or Medicare Letter from other employer, Medicaid, or Medicare documenting time and reason for loss of discontinuation required	Enroll in single or family coverage Change to any available option
	Your spouse or your only enrolled dependent's employment status changes, resulting in a gain of coverage under a qualified plan Letter from other employer documenting affect on coverage eligibility required	Change to single coverage Discontinue coverage

	If you have one of these events:	Within 31 days of event, you may:
	Your former spouse loses coverage or plan is cancelled, resulting in loss of your dependent child(ren) coverage Letter from other plan documenting loss is required	Change to family coverage
	You acquire new coverage under spouse's employer's plan Letter from other plan documenting your coverage is required	Change to single coverage Discontinue coverage – you must document your spouse's coverage and current coverage for all dependents previously covered by your SHBP coverage
	Your spouse makes an Open Enrollment change under spouse's employer's plan, creating an overlap or break in coverage because spouse's coverage has a different plan year Letter from other plan documenting overlap or break in coverage is required	Enroll Change to single coverage Discontinue your coverage - you must document your spouse's coverage
	You, your spouse, or enrolled dependent moves out of your HMO service area	Change to any available option Discontinue coverage – documentation of change in residence may be required

	If you have one of these events:	Within 31 days of event, you may:
	Your HMO goes out of operation	Change to any available option – if you do not file your Membership/Miscellaneous Form within 31 days, you and any Covered dependent(s) will be enrolled automatically into the PPO Option
	You or your spouse is activated into military reservist services Copy of orders required	Enroll in any available option Change coverage type
	You retire and immediately qualify for a retirement annuity You must complete and submit Plan enrollment form no later than 60 days after leaving active employment	Change to any available option or from family to single coverage when you retire

	If you have one of these events:	Within 31 days of event, you may:
	You, your spouse, or all enrolled dependents become eligible for Medicare or Medicaid Letter from Medicare or Medicaid documenting eligibility required	Discontinue your coverage Change to single coverage – if you are retired and you discontinue your SHBP coverage when you enroll for Medicare, you won't be able to enroll again for SHBP coverage Retirees may change to any available option upon becoming eligible for Medicare coverage. Change to any available option or from family to single coverage when you retire

If you lose all your Covered Dependents because of death, divorce, marriage of dependent, age, loss of full-time student status or other qualifying reason, you have *90 days from the date of the event* to complete the necessary form(s) to request a change from family to single coverage.

Qualified Medical Child Support Orders

You may make coverage changes during the Plan Year when you receive a Qualified Medical Child Support Order (QMCSO).

	If a QMCSO requires:	You can file a Membership Form to:
	You to provide coverage for your natural child(ren).	Enroll or change from single coverage to family coverage – there is no time limit for this change; documentation of the court order is required
	Your former spouse to provide coverage for each of your enrolled natural child(ren)	Change from family to single coverage – within 90 days of the court-ordered date; documentation of the court order is required Generally, a change in coverage takes effect the first of the month following receipt of the change request.

Important Note on Coverage Changes:

If your current Plan option is not offered in the upcoming Plan Year and you do not elect a different option available to you during Open Enrollment or the Retiree Option Change Period, your coverage will be transferred automatically to the PPO Option effective January 1 of the subsequent Plan year.

How to Request a Change

During Open Enrollment and the Retiree Option Change Period, Members can go online to make coverage changes for the upcoming Plan Year. See the current *Health Plan Decision Guides* for Web addresses and instructions. If you do not have Internet access or if your request is in the middle of a Plan year, then:

- **Notify your personnel/payroll office.** Ask for the *Membership Form* and other required forms. If you are retired, contact the SHBP eligibility unit directly or your former employer's personnel office.
- **Return completed forms** with requested documentation to your personnel/payroll office, the SHBP or your retirement system. You must make your change by the appropriate deadline.

If you miss the deadline, you won't be able to make your change until the next Open Enrollment period. Changes permitted for retirees are limited, please refer to the retiree section for more details.

Provisions for Eligible Retirees
- and considerations for Participants near retirement

Plan Membership

This section includes Plan Membership and co-ordination of benefits information for eligible retirees as well as important points to consider if you are near retirement. Effective January 1, 2006, SHBP will implement a new Medicare policy. SHBP will pay primary benefits for non-enrolled Medicare eligible retirees as well as retirees who are not entitled to Medicare because they did not participate in Social Security or pay Medicare taxes.

Eligibility

You may be able to continue Plan coverage if you are enrolled in the Plan when you retire and are immediately eligible to draw a retirement annuity from any of these systems:

- Employees' Retirement System
- Teachers Retirement System
- Public School Employees Retirement System
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Important Note: Individuals who have withdrawn money from their respective retirement system will not be able to continue health coverage as a retiree. Eligibility for temporary extended coverage under COBRA provisions would apply.

Applying for Coverage Continuation

If you are an eligible retiree, you must apply for continued coverage for yourself and Covered Dependents within 60 days of the date your active coverage ends. Application can be made on a *Retirement/Surviving Spouse Form,* available through your personnel/payroll office or by contacting the Plan's Eligibility Section. **Failure to apply timely or make the appropriate premium payments terminates your eligibility for retiree coverage.**

When Coverage Begins

If you are eligible for a monthly annuity at the time your retire, your coverage starts immediately at retirement, provided that you make proper premium payments or have them deducted from your annuity check. Coverage for your dependents (if you elect to continue dependent coverage) starts on the same day that your retiree coverage begins. A change from single to family coverage as a retiree is allowed only when you have a qualifying event.

For You

Coverage will end when you discontinue coverage or fail to pay premiums on time.

For Your Dependents

Coverage for your dependents will end when:

- They are no longer eligible
- You change from family to single coverage
- You do not pay premiums on time
- Your coverage as a Participants ends.

Keep in mind that if you drop dependents from your coverage, you will *not* be able to enroll them again – unless you have a qualifying event.

Continuing Dependent Coverage at Your Death

In the event of your death, your surviving spouse or eligible dependents should contact the applicable retirement system (ERS, TRS, PSERS, etc.) and the Plan as soon as possible. To continue coverage, surviving spouses or eligible children must complete a Retirement/Surviving Spouse Form and send it to the Plan within 90 days of your death.

Plan provisions vary for survivors:

Surviving spouse receives annuity

- Plan coverage may continue after your death
- Premiums will be deducted from annuity
- Spouse sends payments directly to Plan if annuity is not large enough to cover premium

Surviving spouse does not receive annuity

- Plan coverage may continue after your death when spouse was married to you at least one year before death
- Spouse sends payments directly to the Plan
- Coverage ends if surviving spouse remarries

Surviving child receives annuity

- Plan coverage may continue for each eligible child receiving an annuity larger than the Plan premium
- Member sends payments directly to Plan if annuity is not large enough to cover premium
- Surviving spouses may continue coverage by sending premiums to the Plan

Surviving child does not receive annuity and there is no surviving spouse

- Plan coverage may continue under COBRA provisions
- New dependents or spouses *cannot* be added to survivor's coverage
- Dependent child coverage ends when the child becomes ineligible

Making Changes to Your Retiree Coverage

You can make changes to your coverage only at these time:

- When you have a qualifying event
- During the annual Retiree Option Change Period
    - You may change your Plan option only
    - Adding dependents is not permitted unless you have a qualifying event as described in the section below:

Qualifying Events

You can make changes to your coverage if you have a qualifying event. The coverage change must be consistent with the qualifying event.

If you have this event…	You may…
Within 31 days of eligibility for retiree coverage Annuity no longer covers premium amount Become eligible for Medicare	Change to an available option
Acquire dependent because of marriage, birth, adoption or Qualified Medical Child Support Order (QMCSO) Within 31 days of loss of a dependent's health benefit coverage through spouse's or former spouse's Medicaid, Medicare, group or COBRA coverage	Change from single to family coverage* Proper documentation is required **Surviving spouses and dependents cannot change from single to family coverage*
Spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified health plan	Change coverage type within 31 days of the qualifying event; proper documentation is required

If you have this event…	You may…

	You and spouse are both retirees who both have sufficient retirement benefits from a covered retirement system to have Plan premiums deducted	Change at any time from family coverage to each having single coverage; a request to change from family to single for you and the request for single coverage for your spouse must be filed at the same time

You must request a coverage change within 31 days of the qualifying event by:

- Contacting the Plan directly
- Returning the necessary form(s) with any requested documentation to the Plan by the deadline. Fill out the form(s) completely.

If you miss the deadline, you will not have another change to make the desired change. If the deadline is met, your change will take effect on the first day of the month following the receipt of your request.

Changes Permitted Without A Qualifying Event

Retirees may change from family to single coverage, or discontinue coverage at anytime by submitting the appropriate Plan form. However, if you change from family to single coverage, you cannot increase your coverage later without a qualifying event. Also, if you discontinued coverage, you may not enroll later.

Important Note On Coverage Changes: If your current Plan option is not offered in the upcoming Plan Year and you do not elect a different option available to you during the Retiree Option Change Period, your coverage will be transferred automatically to the PPO Option effective January 1 of the subsequent Plan Year.

Retiree Option Change Period

During the 30-day Retiree Option Change Period – generally from mid-October to mid-November each Plan Year – you can make these changes to your coverage:

- Select a new coverage option
- Change from family to single coverage
- Discontinue coverage (Note that re-enrollments are not allowed.)

Changes will take effect the following January 1.

Before the Retiree Option Change Period begins, the Plan will send you a retiree information packet. The packet will include:

- Information on the Plan options
- Steps for notifying the Plan about coverage selections for the new Plan Year
- Forms you may need to complete
- Informational resources.

To ensure that you receive the information packet, make sure the Plan always has your most up-to-date mailing address.

If You Return to Active Service

If you choose to return to active service with an employing entity under the Plan, whether immediately after you retire or at a later date, your retirement annuity may be suspended or continued. Health Plan coverage, however, must be purchased as an active employee and through payroll deduction by your employer. You will need to complete enrollment paperwork with your Employer and the appropriate form to have the deduction stopped with the retirement system.

When you return to retired status, retiree coverage may be reinstated after notifying the Plan within 60 days. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a retiree. Under Georgia law the SHBP is required to subordinate health benefits to Medicare benefits.

If you retired before the initial legislative funding for a particular employee group, you will not be entitled to retiree Plan coverage – unless the final service period qualifies you for a retirement benefit from a state-supported retirement system.

Impact of Medicare on Benefits

Coordination of Benefits With Medicare

Medicare is the country's health insurance program for people age 65 or older who qualify based on Medicare eligibility rules. Medicare also covers certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure.

To prevent duplicate benefit payment, the Plan coordinates benefits with Medicare and any other plan that may cover you and your dependents. The first step in coordination is the determination of which plan is primary – or which plan pays benefits first - and which plan is secondary. Under Georgia law, the SHBP is required to subordinate health benefits to Medicare benefits.

The chart below provides important details related to primary and secondary coverage based on your Medicare status:

	If you are retired and …	The Plan will pay…
	…age 65, Medicare-eligible and enrolled in Part A and Part B; consider enrolling prior to the month in which you turn 65 to maximize coverage	Secondary benefits starting on the first day of the month in which you turn 65
	…age 65, Medicare-eligible and do *not* enroll in Part A and Part B	Primary benefits; however, Plan premium will increase
	…age 65 or older and not entitled to Medicare	Primary benefits; however, Plan premium will increase

When Coverage May Be Continued

Certain situations allow you to continue your SHBP coverage.

Unpaid Leaves of Absence

If you are an active employee on an approved unpaid leave, you may be able to continue your current coverage for up to 12 calendar months – or up to 18 calendar months for military leave.

Unpaid leave is available for:

- Disability/illness – more details below
- Educational instruction
- Employee's convenience
- Employer's convenience
- Family medical reasons as provided under the Family and Medical Leave Act (FMLA) – more details below
- Military duty (emergency and voluntary) – more details below
- Suspension of employment

You will have to meet certain requirements for each leave type and your personnel/payroll office can provide you with the necessary information, including premium rates and a *Request to Continue Health Benefits During Leave of Absence Without Pay* form. Also, most leave types require supporting documentation.

You can apply for continued coverage within 31 days after starting an unpaid leave.

Continuing Coverage During Approved Disability Leave

In case you become disabled while an active employee, the Plan has provisions that may allow you to continue coverage, which are described in the table below:

Because of a disability, you have this situation:	***You will be affected in this way:***
• You are Totally Disabled and are on an approved disability leave OR • You return to work on a part-time basis before the end of your approved disability leave and before returning to full-time work	• You may be eligible to continue health benefits for up to 12 months • You must pay premiums directly to SHBP • Coverage is limited to whichever is less: — The disability period that your Physician certifies you must provide additional documentation of your disability period — 12 consecutive months if the disability continues

If you are a disabled retired Member, see Provisions for the Eligible Retirees for more information on how your coverage may be affected

Continuing Coverage Under Family and Medical Leave Act (FMLA)

You may continue medical coverage for yourself and your dependents for up to 12 weeks for specific medical and/or family medical reasons. Forms for continuing your coverage are available from your personnel/payroll office.

During FMLA leave without pay, the SHBP will bill you directly for coverage premiums. How FMLA affects your coverage depends on the circumstances involving your leave.

If you have this situation:	***The impact is:***
• Choose not to continue coverage while on leave	• Claims will not be paid by SHBP for the period after coverage terminates and while you remain on leave. You are responsible for paying Providers • You must resume coverage when you return to work
• Open Enrollment period occurs while on leave	• If you continue coverage while on leave, you may change coverage as permitted during Open Enrollment • If you do not continue coverage while on leave, contact your employer for Open Enrollment information
• Do not return to work after your leave ends and you have paid your premiums directly to the Plan during your leave	• You may be eligible to continue your medical coverage through COBRA

Continuing Coverage During Military Leave

You and your dependents have the right to continue your coverage for up to 18 months with premium payments sent directly to the SHBP.

- If you are an activated military reservist called on an emergency basis, you will pay your employee share of the premium.
- For other military leaves, you will be required to pay the full premium. Also, you will be charged a monthly processing fee.

You may elect to discontinue coverage while on leave. The SHBP will reinstate your coverage when you return from military service. However, for the time period allowed by the Veteran's Administration, the Plan does not cover care for a Participant's illness or injury that the Secretary of Veterans' Affairs determines was acquired or aggravated during the military leave.

If You Leave Your Job

This chart shows how your coverage would be affected if you were to leave your job:

If you have this situation:	*You will be affected in this way:*
• Leave your job with less than eight years of service • Take another job that does not qualify you for coverage • Move to part-time status • Are laid off	• You can continue coverage for up to 18 months under COBRA provisions (See pages 92-96 for more information on COBRA coverage)
Leave your job and: • Have at least eight years of service, but less than 10 years	You can continue coverage by: • Submitting the appropriate forms(s) within 60 days of when your coverage would end • Paying the full cost of coverage, except Subscribers under the Legislative Retirement System • Providing a statement from your employer verifying your service
Leave your job and: • Have at least 10 years of service, but before minimum age to qualify for an immediate retirement annuity • You leave money in retirement system	You can continue coverage by: • Submitting the appropriate forms(s) within 60 days of when your coverage would end • Paying the full cost of coverage until your annuity begins • Paying a lower Member premium once your annuity begins

See provisions for Eligible Retirees for more information about how coverage is affected when you leave your job and are immediately eligible to draw a retirement annuity.

In the Event of an Active Employee's Death

The benefits available to your survivors will depend on your length of service.

- When your surviving spouse receives an annuity from a qualifying retirement system, your covered survivor(s) can continue Plan coverage if your surviving spouse:
  - — Elects to receive his or her benefits as an annuity (versus a lump-sum benefit)
  - — Sends the Plan a Retirement/Surviving Spouse Form within 90 days after your death

Surviving children can continue coverage until they are ineligible under Plan rules – dependents may not be added after your death

- When your surviving spouse does not receive an annuity or when a lump-sum benefit is elected, your survivor(s) can continue coverage through COBRA

See provisions for Eligible Retirees for information on survivor coverage in the even of a retiree's death.

Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Network provider, you are responsible for filing a claim.

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact United HealthCare. However, you are responsible for meeting the Annual Deductible and for paying Copayments/Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

To continue reading, go to right column on this page.

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a non-Network provider, as described below.

You must submit a request for payment of Benefits within 24 months following the month of service. If you do not submit this information within the specified time limit the claim will not be paid. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Pharmacy Benefit Claims

If you are asked to pay the full cost of a prescription when you fill it at a retail pharmacy and you believe that the Plan should have paid for it, you may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim (described in this section). If you pay a Copayment and you believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim.

If a retail or pharmacy fails to fill a prescription that you have presented, you may contact United HealthCare by submitting a claim for coverage as set forth in the procedures for filing a pre-service health plan claim (described in this section).

To continue reading, go to left column on next page.

Required Information

When you request payment of Benefits from us, you must provide all of the following information:

A. Participant's name and address.
B. The patient's name, age and relationship to the Participant.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:
   — Patient diagnosis
   — Date of service
   — Procedure code(s) and description of service(s) rendered
   — Provider of service (Name, Address and Tax Identification Number)
E. The date the Injury or Sickness began.
F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

Through United HealthCare, we will make a benefit determination as set forth below.

You may assign your Benefits under the Plan to a non-Network provider. United HealthCare may, however, in their discretion, pay a non-Network provider directly for services rendered to you.

To continue reading, go to right column on this page.

United HealthCare will notify you if additional information is needed to process the claim. United HealthCare may request a one time extension not longer than 15 days and will pend your claim until all information is received. Once you are notified of the extension or missing information, you then have at least 45 days to provide this information.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from United HealthCare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. United HealthCare will notify you within this 30-day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, United HealthCare will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

To continue reading, go to left column on next page.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim is a pre-service claim, and is submitted properly with all needed information, you will receive written notice of the claim decision from United HealthCare within 15 days of receipt of the claim. If you filed a pre-service claim improperly, United HealthCare will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, United HealthCare will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, United HealthCare will notify you of the pre-determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after United HealthCare receives all necessary information, taking into account the seriousness of your condition.

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- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, United HealthCare will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, United HealthCare will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- United HealthCare's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. United HealthCare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described above. If an on-going course of treatment was previously

To continue reading, go to left column on next page.

approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

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To continue reading, go to left column on next page.

Section 6: Questions, Complaints and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- How to handle an appeal that requires immediate action.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

United HealthCare Insurance Company
PO Box 30994
Salt Lake City, Utah 84130-0432

To resolve a question or appeal, just follow these steps:

To continue reading, go to right column on this page.

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in (Section 5: How to File a Claim) you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of United HealthCare.

If you are appealing an urgent care claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact United HealthCare in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.

To continue reading, go to left column on next page.

- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to United HealthCare within 180 days after you receive the claim denial.

Appeal Process – How to Appeal an Eligibility Decision

SHBP will handle all eligibility appeals. Please forward all eligibility appeals to: State Health Benefit Plan, Membership Correspondence Unit P.O. Box 38342, Atlanta, GA 30334. All Member correspondences sent to the Plan should include the Participant's Social Security Number (SSN). Including your SSN will help prevent delay in processing your requests

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service claims, as defined in (Section 5: How to File a Claim), the first level appeal will be conducted and you will be notified by United HealthCare of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by United HealthCare of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims as defined in (Section 5: How to File a Claim), the first level appeal will be conducted and you will be notified by United HealthCare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by United

To continue reading, go to right column on this page.

HealthCare of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of United HealthCare, you have the right to request a second level appeal from United HealthCare. Your second level appeal request must be submitted to United HealthCare in writing within 60 days from receipt of the first level appeal decision.

For pre-service and post-service claim appeals, SHBP have delegated to United HealthCare the exclusive right to interpret and administer the provisions of the Plan. United HealthCare's decisions are conclusive and binding.

Please note that United HealthCare's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call United HealthCare as soon as possible. United HealthCare will provide you with a written or electronic determination within 72 hours following receipt by United

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HealthCare of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to United HealthCare the exclusive right to interpret and administer the provisions of the Plan. United HealthCare's decisions are conclusive and binding.

Voluntary External Review Program

If a final determination to deny Benefits is made, you may choose to participate in our voluntary external review program, at your cost. The cost can range from $500 - $2,000. This program only applies if the decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental, Investigational or Unproven Services.

The external review program is not available if the coverage determinations are based on explicit Benefit exclusions or defined Benefit limits.

Contact United HealthCare at the telephone number shown on your ID card for more information on the voluntary external review program.

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Section 7: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Filing a Claim When Coordination of Benefits (COB) applies

You and your Covered dependents may have medical coverage under more than one plan. In this case, the Plans coordination of benefits (COB) provisions apply.

When SHBP benefits are coordinated, the Plan does not pay more than 100% of the Plan's Allowed Amount. Non-Covered Services or items, penalties, and amounts Balance Billed are not part of the Allowed Amount and are the Participant's responsibility.

- COB applies to group health coverage, including:
  - Government programs such as Medicare or state contracts (dual SHBP coverage
  - Your spouse's insurance at his or her work
  - COBRA coverage

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- COB does not apply to an individual policy – one for which you pay the total premium directly to the insurer.

If the 24-month timely filing limit is approaching and you have not received an explanation of benefits (EOB) from the primary plan, submit your claim(s) to the Plan without the EOB prior to the deadline. When you receive the EOB, send it to the Plan for processing, even if the deadline has passed.

For COB information that applies when you or a Covered Dependent is injured in an accident caused by another party, see *Subrogation.*

How COB works

- When you or your dependents are covered by two group health plans, **determine which plan is the primary and which is secondary.** The primary plan is obligated to pay a claim first, which generally means that it will pay most of the expenses.
- **Submit claims to the primary plan first.** You will receive a benefit payment from that plan along with an explanation of benefits (EOB).
- **Make a copy of the EOB you received from the primary plan, attach it to a claim form and mail both to the secondary plan.** The SHBP won't pay a secondary benefit until you submit the primary plan's EOB. Indicate the name and policy number of the person who has the other coverage and that plan's group number.

If your other group coverage ends, you must report the cancellation date to Member Services in writing and include supporting documentation from the primary plan. You can get

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the information from your employer or from the other insurance company.

How to Tell Which Plan is Primary

Generally, a plan is primary when:

- The patient is the Participant or employee
- The plan does not have coordination of benefits
- The plan is a Workman's Compensation Plan or an automobile insurance medical benefit
- The other plan is Medicare and the patient is covered under the group plan of an active employee. Those under the age 65 may qualify for Medicare because of a covered disability or end-stage renal disease. Your Plan coverage will be primary during the first part of your Medicare participation, then Medicare will become primary. Medicare determines the length of time Plan coverage is primary.

In other situations, determining which plan is primary is more complicated:

- **If the patient is a dependent child with married parents,** the plan that covers the parent whose birthday comes first in the Calendar year is primary, unless the parents are divorced. If both parents were born on the same date, the plan that has covered the parent for the longest time pays first.

When a plan uses the gender rule to determine the primary plan, the father's plan is primary. If the other plan follows the gender rule, the SHBP will allow the father's plan to be primary.

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- **When the patient is a dependent child whose parents are divorced,** the plan of the parent with custody pays first, except where a court decrees otherwise.
- **If the parent with legal custody has remarried:**
  - The plan of the parent with legal custody pays first.
  - The Plan of the spouse of the parent of the parent with custody pays second.
  - The plan of the parent who does not have custody pays last.

  If custody is joint, the plan that covers the parent whose birthday comes first in the Calendar Year is primary.
- **When two plans cover the Member as an active employee,** the plan that has covered the employee the longest pays first.
- **For active employees versus inactive employees,** a plan that covers a person:
  - As an active employee is primary over a plan that covers a person as an inactive employee, such as a person who is retired, laid off or covered under COBRA.
  - As an inactive employee is primary over a plan that covers that person as the spouse of an active employee, except when the inactive employee is covered by Medicare.
  - As a dependent of an active employee is primary over Medicare coverage for a retiree.

If You Have Dual Plan Coverage

Coordination of benefits when both you and your spouse have Plan coverage as Subscribers (i.e., when you have dual coverage) works like this:

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- If one of you has family coverage and the other has single coverage, only the spouse with the single coverage has dual coverage.
- When both spouses have dual coverage, the coverage of the spouse who is the patient is primary.
- If the patient is a dependent, then the plan that covers the parent whose birthday comes first in the Calendar year is primary.

When you have dual coverage, you cannot transfer Deductibles between Plan contracts.

Coordination of Pharmacy Benefits

- If you have other insurance that is primary, you must first use that plan to pay for your prescription. Then you can file a Prescription Drug Claim form. On the form, indicate whether the patient is covered under any other group health insurance plan. Then attach a copy of the EOB from the other plan to the claim form and mail them to the address on the claim form. If the other plan does not issue and EOBs, then attach prescription receipts from the pharmacy. A secondary benefit will not be paid when the reimbursement amount is equal to or less than your SHBP Prescription Drug Co-payment.

- If you have dual Plan coverage, benefits will **not be** coordinated. You will need to make Co-payments for each covered prescription. To take advantage of the Out-of- Pocket Limit, only use one Plan ID card- primary or secondary- for all prescription purchases.

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Other Forms of Duplicated Benefits

- The Plan does not duplicate payments that your may receive under third-party medical payment contracts or because of any lawsuit, including malpractice litigation.
- If you receive medical payments from underwriters of a homeowner's policy, an automobile insurance policy or any other payment plan, the Plan will consider only those charges over the amounts paid by the third party(ies).
- The Plan has the right to delay your payments until it determines whether or not other parties are liable for paying your medical expenses. However, when the employee or Covered Dependent must sue to determine the parties' obligations, the Plan will not delay payment-provided that you or the payee agrees to reimburse the Plan for duplicated medical payments.

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Section 8: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Continuation of coverage under federal law (COBRA).

General Information about When Coverage Ends

We may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

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Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

For You

Your coverage generally will end if:

- You no longer qualify under any category listed under the eligibility rules and your payroll deductions for coverage have ceased.
- You do not make direct-pay premium payments on time
- You resign or otherwise end your employment
- You are laid off because of a formal plan to reduce staff
- Your hours are reduced so that you are no longer benefits eligible
- You do not return to active work after an approved unpaid leave of absence
- You are terminated by your employer

Coverage for Participant ends at the end of the month following the month in which the last premium is deducted from your earned paycheck or at the end of paid coverage. Premiums will not be deducted from final leave pay.

For Your Dependents

Coverage for your dependents will end at the same time you lose coverage because you are no longer eligible. Here are other situations that can affect coverage for you and your dependents.

Situation	Effect on coverage
If enrolled dependent is a stepchild under age 19 and does not meet the 180-day residency requirement	Coverage ends at the end of the month in which dependent moves out
If enrolled dependent is a Full-time Student at an accredited college, university or other institution	Coverage ends on the last day of the month in which the earliest of these events occurs: Graduation or completion of requirements if graduation is delayed Full-time attendance ends – unless child has attended previous tow semesters and plans to return after a one semester break Dependent reaches age 26 Dependent marries Dependent becomes employed in a benefits-eligible position
If you or your spouse or eligible dependent(s) loses other group health insurance coverage because of change in employment	Before you lose coverage or within 31 days after losing coverage, file your request for SHBP coverage, which will start on the first day of the month following the request

	Situation	Effect on coverage
	If you divorce and your spouse loses coverage as your dependent*	Coverage ends at the end of the month in which the divorce becomes final
	If you declined coverage for yourself or your dependents because of other group health insurance coverage, and you later lose that coverage	You may enroll yourself or you family if you request this coverage within 31 days of the event

* If you receive a court order to provide health coverage for a divorced spouse, you may temporarily continue Plan coverage for the divorced spouse by electing COBRA continuation coverage, which is limited to 36 months of coverage. You must request a COBRA information packet from the SHBP within 60 days of the event.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Participant that coverage has ended on the date SHBP identifies in the notice:

Ending Event	What Happens
Failure to Pay	You failed to pay a required contribution.

Coverage for a Disabled Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Participant for support.

Coverage will continue as long as the Enrolled Dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

We will ask you to furnish SHBP with proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before SHBP agrees to this extension of coverage for the child, SHBP may require that a Physician chosen by us examine the child. We will pay for that examination.

SHBP may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's incapacity and dependency within 31 days of SHBP's request as described above, coverage for that child will end.

To continue reading, go to right column on this page.

Continuation of Coverage

If your coverage ends under the Plan, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Participant.
- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
- A Participant's former spouse.

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Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the Participant from employment with us, for any reason other than gross misconduct, or reduction of hours; or
B. Death of the Participant; or
C. Divorce or legal separation of the Participant; or
D. Loss of eligibility by an Enrolled Dependent who is a child; or
E. Entitlement of the Participant to Medicare benefits; or
F. The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Participant and his or her Enrolled Dependents. This is also a qualifying event for any retired Participant and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Participant or other Qualified Beneficiary must notify SHBP within 60 days of the Participant's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Participant or other Qualified Beneficiary fails to notify SHBP of these events within the 60 day period, SHBP is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under Federal Law, the Participant must notify SHBP within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from SHBP.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

To continue reading, go to left column on next page.

Notification Requirements for Disability Determination or Change in Disability Status

The Participant or other Qualified Beneficiary must notify the Plan Administrator as described under "Terminating Events for Continuation Coverage under federal law (COBRA)", subsection A. below.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Attachment II to this Summary Plan Description. The contents of the notice must be such that the Plan Administrator is able to determine the covered

employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Participant or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to SHBP, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator.

The Qualified Beneficiary's initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation.

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The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

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Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Plan will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Participant's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

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B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Participant, divorce or legal separation of the Participant, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).

C. For the Enrolled Dependents of a Participant who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Participant's Medicare entitlement.

D. The date coverage terminates under the Plan for failure to make timely payment of the premium.

E. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.).

G. The date the entire Plan ends.

H. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

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If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Participant's death. Terminating events B. through G. described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Participant becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact SHBP for information regarding the continuation period.

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Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning the Plan.

Plan Document

This Summary Plan Description presents an overview of your benefits. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all time.

Relationship with Providers

The relationships between SHBP, United HealthCare, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees; nor are they agents or employees of United HealthCare. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits for Covered Services. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not our employees or employees of United HealthCare; nor do we have any other relationship with Network providers such as principal-agent or joint venture. Neither we nor United HealthCare are liable for any act or omission of any provider.

To continue reading, go to right column on this page.

United HealthCare is not considered to be an employer of the SHBP for any purpose with respect to the administration or provision of benefits under this Plan.

We and the United Healthcare are solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of Plan Sponsor and employee, Dependent or other classification as defined in the Plan.

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Incentives to Providers

United HealthCare pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation - a group of Network providers receives a monthly payment for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The methods used to pay specific Network providers may vary. From time to time, the payment method may change. If you have questions about whether your Network provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact United HealthCare at the telephone number on your ID card. They can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

To continue reading, go to right column on this page.

Incentives to You

Sometimes United HealthCare may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact United HealthCare if you have any questions.

Rebates and Other Payments

SHBP and United HealthCare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. SHBP and United HealthCare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copayments.

Interpretation of Benefits

SHBP and United HealthCare has sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.
  Make factual determinations related to the Plan and its Benefits.

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SHBP and United HealthCare may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Plan

We reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Plan. Plan Amendments and Riders are effective on the date we specify.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

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Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of any material modification to the Plan. No one has the authority to make any oral modification to the SPD.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including United HealthCare, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or United HealthCare may need additional information from you. You agree to furnish us and/or United HealthCare with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or United HealthCare with all information or copies of records relating to the services provided to you. We or United HealthCare have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form.

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We and United HealthCare agree that such information and records will be considered confidential.

We and United HealthCare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, United HealthCare, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or United HealthCare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as SHBP.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

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Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a Benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover Benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted to as supplied by a workers' compensation, liability insurance carrier, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable.

We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and Benefits we provided to you from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or

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uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties").

You agree as follows:

- To assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That our rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.
- That you will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Plan.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name.
  That regardless of whether or not you have been fully compensated, we may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the Plan.
- To hold in trust for our benefit under these subrogation provisions any proceeds of settlement or judgment.
- That we shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval.

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- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.
- We will not pay fees, costs or expenses you incur with any claim or lawsuit, without our prior written consent.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

If you want to bring a legal action against us or United HealthCare you must do so within three years from the expiration of the time

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period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or United HealthCare.

You cannot bring any legal action against us or United HealthCare for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us or United HealthCare you must do so within three years of the date you are notified of our final decision on your appeal, or you lose any rights to bring such an action against us or United HealthCare.

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Section 10: Glossary of Defined Terms

This section:
- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by the SHBP or the UHC. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before the SHBP will begin paying for Benefits in that calendar year.

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The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. See the definition of Eligible Expenses below.

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Clinical Cancer Trial Services - clinical trials study the effectiveness of new interventions. There are different types of cancer clinical trials such as:

- prevention trials;
- early detection trials;
- treatment trials to test new therapies in individuals who have cancer;
- quality of life studies;
- studies to evaluate ways of modifying cancer-causing behaviors.

Clinical trials follow strict scientific guidelines that deal with many areas such as:

- study design,
- who can be in the study,
- the kind of information individuals in the study must be given when they decide to participate.

Clinical trials follow protocols for determining:
- the number of participants;
- what drugs participants will take;

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- what medical tests they will have; and
- how often and what information will be collected.

There are four phases of clinical trials. Clinical trials pilot program will include all phases of clinical trials, as long as they meet the criteria defined for the program.

Phase I Trials evaluate how a new drug should be administered and enroll only a small number of patients.
Phase II Trials provide preliminary information about how well a new drug works and generates more information about safety and benefits of the new drug or procedure.
Phase III Trials compare a promising new drug, a combination of drugs or a procedure with the current standard. This phase involves large numbers of people in doctors' offices, clinics and cancer centers. (Many of our members will be in this category). This phase utilizes a randomized process of assigning participants to the standard intervention or the trial intervention.
Phase IV Trials continue the evaluation of drugs after FDA approval and utilize drugs already on the market and available for general use.

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by United HealthCare on behalf of SHBP.

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Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

Covered Person - either the Participant or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person. Also referred to as "Member".

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - your eligible dependents that participates in the Plan, which can include an eligible spouse, child, full-time student or totally disabled child.

Designated Facility - a facility that has entered into an agreement on behalf of the facility and its affiliated staff with United HealthCare or with an organization contracting on its behalf to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be

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located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable. accept urinary catheters and ostomy supplies
- ,Is manufactured and used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Expenses - for Covered Health Services incurred while the Plan is in effect, Eligible Expenses are determined as stated below:

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged through United HealthCare, Eligible Expenses are billed charges unless a lower amount is negotiated.

Eligible Person - The Participant who may be the employee, teacher, retiree, contract employee or extended beneficiary who is eligible for Plan coverage and who has paid the necessary deduction or premium for such coverage.

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Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health

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Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, occupational, specialized or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar month you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law, that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time, as determined by the SHBP, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Maximum Plan Benefit - the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Plan, or any other plan of the Plan Sponsor. When the Maximum Plan Benefit applies, it is described in (Section 1: What's Covered--Benefits).

Medicare - Parts A, B and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

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Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Abuse Designee - the organization or individual, designated by United HealthCare, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with United HealthCare or with United HealthCare's affiliate to participate in United HealthCare's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. United HealthCare's affiliates are those entities affiliated with them through common ownership or control with United HealthCare or with its ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of United HealthCare's products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

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Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan, as determined by the SHBP.

Out-of-Pocket Maximum - the maximum amount of Annual Deductible and Copayments you pay every calendar year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services;
- Copayments for Covered Health Services available by an optional Rider.
- Any Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

Participant - an Eligible Person who is properly enrolled under the Plan. The Participant is the person (who is not a Dependent) on whose behalf the Plan is established.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or

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her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - Choice Plan for Georgia Department of Community Health State Health Benefit Plan.

Plan Administrator – is Georgia Department of Community Health.

Plan Sponsor - Georgia Department of Community Health. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Qualified Medical Child Support Order (QMCSO) – Any judgment, decree, order (including approval of a settlement agreement), or National Medical Support Notice that a court of competent jurisdiction or a state agency issues. The order must provide for medical coverage for your natural child.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

SHBP – State Health Benefit Plan.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

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Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Transition of Care- Transition of care is a service that enables new enrollees to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and United HealthCare may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and United HealthCare must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Attachment I

Choice Plan

Outpatient Prescription Drug Rider

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Outpatient Prescription Drug Rider

This Rider to the Summary Plan Description provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms) of the Summary Plan Description and in (Section 3: Glossary of Defined Terms) of this Rider.

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When we use the words "we," "us," and "our" in this document, we are referring to Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Summary Plan Description (Section 10: Glossary of Defined Terms).

NOTE: The Coordination of Benefits provision (Section 7: Coordination of Benefits) in the Summary Plan Description does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

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Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products on the Prescription Drug List at a Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the three tiers of the Prescription Drug List the Outpatient Prescription Drug is listed.

Coverage Policies and Guidelines

United HealthCare's Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates, and assessments on the cost effectiveness of the Prescription Drug Product.

United HealthCare may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally

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will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in Summary Plan Description (Section 5: How to File a Claim). When you submit a

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claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment, Ancillary Charge, and any deductible that applies.

Designated Pharmacies

If you require certain Prescription Drug Products, United HealthCare may direct you to a Designated Pharmacy with whom they have an exclusive arrangement to provide those Prescription Drug Products.

In this case, Benefits will only be paid if your Prescription Order or Refill is obtained from the Designated Pharmacy.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

United HealthCare, and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug Rider. Such business may include, but is not limited to, data collection, consulting,

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educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug Rider. United HealthCare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we or United HealthCare may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

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Section 1: What's Covered--Prescription Drug Benefits

We provide Benefits under the Plan for outpatient Prescription Drug Products:

- Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network Pharmacy.
- Refer to exclusions in your Summary Plan Description (Section 2: What's Not Covered--Exclusions) and as listed in Section 2 of this Rider.

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

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When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment may change and an Ancillary Charge may apply. You will pay the Copayment applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that United HealthCare has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on your ID card.

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Notification Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify United HealthCare or its designee. The reason for notification is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not Experimental, Investigational or Unproven.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying United HealthCare.

If United HealthCare is not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring notification are subject to periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

If United HealthCare is not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Summary Plan Description (Section 5: How to File a Claim).

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When you submit a claim on this basis, you may pay more because you did not notify United HealthCare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment, Ancillary Charge, and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after the documentation provided is reviewed and it is determined that the Prescription Drug Product is not a Covered Health Service or it is Experimental, Investigational or Unproven.

What You Must Pay

You are responsible for paying the applicable Copayment described in the Benefit Information table, in addition to any Ancillary Charge when Prescription Drug Products are obtained from a retail or home delivery pharmacy.

The Ancillary Charge applies when a covered Prescription Drug Product is dispensed at your request, when a chemically equivalent Prescription Drug Product is available on a lower tier.

The amount you pay for any of the following under this Rider will not be included in calculating **any Out-of-Pocket Maximum stated in your Summary Plan Description**:

- Copayments for Prescription Drug Products
- Ancillary Charges.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

To continue reading, go to left column on next page.

Payment Information

Payment Term	Description	Amounts
Copayment	Copayments for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost. Your Copayment is determined by the tier to which United HealthCare's Prescription Drug List Management Committee has assigned a Prescription Drug Product. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on United HealthCare's Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, your Copayment may change. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. ***See the Copayments stated in the Benefit Information table for amounts.***

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • As written by the provider, two copays for 90-day supply of a Maintenance Drug Product, determined by DCH and United HealthCare. • A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.	**Your Copayment is determined by the tier to which United HealthCare's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.** **Coverage up to 31-day supply:** $10 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product**. $25 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product**. $50 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.** **Coverage from 32-day to 90-day supply**: $20 per Prescription Order or Refill for a **Tier-1**

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
	Prescription Drug Product. $50 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product**. $100 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.**

Section 2: What's Not Covered--Exclusions

Exclusions from coverage listed in the Summary Plan Description apply also to this Rider. In addition, the following exclusions apply:

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
5. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by United HealthCare to be experimental, investigational or unproven.

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6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression and other weight loss products.
9. A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by United HealthCare, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging of Prescription Drug Products.
13. Medications used for cosmetic purposes.

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14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Prescription Drug Products for smoking cessation.
18. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
20. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by United HealthCare's Prescription Drug List Management Committee.
21. Growth-hormone therapy, with the exception of diagnostic testing to rule out a diagnosis. Once diagnosed growth-hormone therapy is not covered.

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Section 3: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Rider. Other defined terms used throughout this Rider can be found in (Section 10: Glossary of Defined Terms) of your Summary Plan Description.
- Is not intended to describe Benefits.

Ancillary Charge - a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a chemically equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC list price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Cost or MAC list price of the chemically equivalent Prescription Drug Product available on the lower tier.

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Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that United HealthCare identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by United HealthCare.

Designated Pharmacy - a pharmacy that has entered into an agreement on behalf of the pharmacy with United HealthCare or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that United HealthCare identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by United HealthCare.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that United HealthCare establishes. This list is subject to periodic review and modification.

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Network Pharmacy - a pharmacy that has:

- Entered into an agreement with United HealthCare or its designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by United HealthCare as a Network Pharmacy.

A Network Pharmacy can be either a retail or a home delivery pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

- The date it is assigned to a tier by United HealthCare's Prescription Drug List Management Committee.
- December 31st of the following calendar year.

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

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Prescription Drug List - a list that identifies those Prescription Drug Products for which Benefits are available under this Rider. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

Prescription Drug List Management Committee – the committee that United HealthCare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;

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— ketone-testing strips and tablets;

— lancets and lancet devices;

— glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

- End of Outpatient Prescription Drug Rider -

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Attachment I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).